In the Matter of Arbitration Between SEIU Local 113 [Kathi Miller] and St. Paul's Church Home

OPINION AND AWARD

FMCS Case No. 050921-59311-7

GRIEVANCE ARBITRATION

ARBITRATOR

Joseph L. Daly

APPEARANCES

On behalf of SEIU Local 113
Roger A. Jensen, Esq.
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On behalf of St. Paul's Church Home
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JURISDICTION

In accordance with the Collective Bargaining Agreement between St. Paul's Church Home, LPN Agreement and SEIU Local 113, July 1, 2002-July 1, 2005; and under the jurisdiction of the United States Federal Mediation and Conciliation Service, Washington, DC, the above Grievance Arbitration was submitted to Joseph L. Daly, Arbitrator, on November 22, 2005 [Postponed due to illness of key witness] and December 14, 2005 in St. Paul, Minnesota.

Post-Hearing Briefs were filed by the parties on December 29, 2005 [SEIU Local 113] and December 30, 2005 [St. Paul's Church Home]. A decision was rendered by the Arbitrator on January 18, 2006.

ISSUES AT IMPASSE

The parties stipulated that the issue for determination by the Arbitrator is:

1. Whether there was just cause for the termination of Kathy Miller, and if not, what is the remedy? [See Post-Hearing Brief of Employer at 3 and Post-Hearing Brief of Union at 1].

The applicable Collective Bargaining Agreement provision is:

ARTICLE X

DISCHARGE-QUITS-DISCIPLINE

A. NO DISCHARGE OR DISCIPLINE WITHOUT JUST CAUSE.

The Employer shall not discharge, suspend or discipline a non-probationary employee without just cause. Grounds for immediate discharge without prior warning shall include but not be limited to drunkenness on the job, possession of intoxicating liquor on the premises, possession of or use of drugs on the premises, theft on the premises, dishonesty or infraction of reasonable rules directly affecting patient abuse, comfort or safety, physical violence and/or having weapons such as guns or switchblades on the premises.

Warning notices issued by the Employer shall not remain in effect for the purposes of discipline twelve (12) months after issuance.

If an employee fails to receive approval of the Employer to be excused from work, such employee shall be subject to progressive discipline. In addition to the foregoing, employees may be disciplined if they are excessively absent.

In the event that an employee fails to receive approval of the Employer to be excused from work and the employee's unexcused absence jeopardizes patient health or safety, such employee shall be subject to immediate discharge.

FINDINGS OF FACT

1. On September 15, 2005, Ms. Kathi Miller, a 28-year employee of St. Paul's Church Home and a Licensed Practical Nurse (LPN) was suspended without pay. On September 21, 2005, she was terminated.

The reasons given for the termination are:

1. Violation against resident safety by advising NAR Detano not to lock brakes on a resident wheelchair which violated good nursing practice and SPCH procedures, and State rules.
2. Lack of follow through to assure that floor mats in resident rooms were and remained in good condition without rips and bad areas which could negatively affect resident safety.
3. Failure to communicate with the Director of Nursing regarding destruction of personal property (an ultrasound photo) that had been defaced and had belonged to an LPN working at SPCH.

4. Failure to create and/or document wound treatment of resident LM where Miller admitted to Violett that she signed off that a treatment had been done but that she did not do it. Miller was asked to get information back to SPCH as to when the last time the wound was viewed, but did not provide this information. See Employer Exhibit No. 3.

Reasons numbers 1, 2 and 4 above directly affect the comfort and safety of residents at SPCH. Any one of these reasons in itself would have justified Miller's termination.. Reason number 4 for the termination also involved dishonesty in that wound treatment care was falsely documented when Miller had no assurances that such wound treatment care had been given. Reason number 3 does not directly affect resident care, but does affect the morale of employees expected to give care. [Post-Hearing Brief of Employer at 3-4].

On September 28, 2005, Nurse Kathi Miller filed a Grievance. It stated in applicable part:

> I was terminated on September 21, 2005 following a five-day suspension without just cause in violation of Article X of our Collective Bargaining Agreement. "I find the accusation in this termination to be either unfounded or proved to be disparate treatment". [Joint Exhibit No. 2]

2. Wheelchair incident.

On September 13, 2005, the State of Minnesota Department of Health Inspectors during the course of an annual inspection were at the St. Paul's Church Home Nursing Care facility. St. Paul's Church Home provides care for adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable. The typical resident of St. Paul's Church Home is an elderly person. Many of the residents have varying degrees of Alzheimer's.

A State of Minnesota inspector in a document entitled "Statement of Deficiencies and Plan of Correction" wrote that she observed a nursing assistant and Nurse Miller "attempt to transfer the resident from the wheelchair to the toilet without locking the brakes of the resident's wheelchair. The surveyor noted that the resident was unable to balance and that [the nursing assistant] lowered her to the wheelchair which rolled back causing the resident to sit on the edge of the seat. Ultimately the resident

was transferred to the toilet after [the nursing assistant] elicited the aid of Miller. However, the wheelchair brakes were not locked at Miller's direction and the wheelchair moved across the bathroom floor striking the wall. When the toileting was completed, according to the surveyor, [the nursing assistant] and Miller walked the resident out of the bathroom and transferred the resident into her wheelchair with the brakes left unlocked. Then the resident was transferred into the bed without the wheelchair brakes locked. The wheelchair rolled back and hit the resident's TV stand a small decorative table". [Post-Hearing Brief of Employer at 6].

The Employer did not call the State of Minnesota Inspector as a witness at the Arbitration hearing.

Ms. Miller and the nursing assistant testified that the resident "was a large elderly woman". "[The nursing assistant] initially attempted to transfer the resident from her wheelchair to the commode in the narrow bathroom, which was between the resident's room and the adjoining resident room. Because of the size of the resident and the narrowness of the bathroom, [the nursing assistant] asked [Ms. Miller] who was the LPN in charge of the area where the resident was located, to assist her." [Post-Hearing Brief of Union at 2]. "They both testified that the State Inspector was standing at the door of the bathroom. Both [Ms. Miller and the nursing assistant] testified that they pushed the wheelchair as close to the commode as possible …. Then they both held the transfer belt which was around the patient's waist with one hand, and lifted her slightly off of her chair and once the resident's weight was off the chair, they both disengaged the locks on the wheelchair wheels, and pushed the wheelchair out from under the resident, giving them room to turn the resident around and sit her on the commode". [Id.]. "They testified that after the resident completed her toileting, they lifted her from the commode, using the transfer belt, and gave the resident her walker. The resident then walked out of the bathroom with her walker, but appeared to be fatigued when she made it to the resident's room. They testified that they moved the wheelchair behind the resident, locked the wheels, and assisted the resident onto the wheelchair". [Id.] "The wheels were then unlocked and the resident was wheeled to a point adjacent to

her bed. The wheels were again locked and the resident was lifted from [the] wheelchair using the transfer belt. After the resident was lifted from the chair with the transfer belt, the wheels were again unlocked and the wheelchair was pushed away while the resident was placed on her bed". [Id. at 2-3].

3. Torn floor mats.

A concern arising out of the annual Department of Health Inspection was floor mats. The St. Paul's Church Home was issued a tag on the initial survey by the Department of Health because of discovery of unsafe floor mats by the inspectors. After the August 2005 survey, meetings were held with Interim Director of Nursing Teri Lee Violett, R.N. with nurse managers, including Kathi Miller, and housekeeping workers to monitor floor mats in the residents' rooms. "Instructions were given to check floor mats both from the top and bottom". [Post-Hearing Brief of Employer at 7]. Nurse Kathi Miller, a nurse manager, assured Director of Nursing Violett that "floor mats in the Memory Care Unit, where Miller was in charge, were being checked regularly and were in good shape for the surveyor's re-visit". [Id.]. "Yet, on the date of the re-survey, at least two of the three floor mats which Miller was responsible as a nurse manager in the Memory Care Unit were cited by surveyors as not being safe for residents". [Id.]

The Union contends that "on the day of the second inspection by the State, Interim Director of Nursing, Teri Lee Violett, observed two floor mats in rooms [Ms. Miller] was responsible for as a nurse manager of the Unit in which the rooms were located. One of the floor mats had a 2-inch tear on the bottom flat surface of the mat and another had an open seam on the edge, which someone had attempted to fix with tape". [Post-Hearing Brief of Union at 5]. "When Nurse Violett confronted [Ms. Miller] regarding the two mats containing tears [Ms. Miller] stated that she did closely inspect all of the mats after the staff meeting, but thereafter, she only inspected the mats by looking at them while making her rounds, not turning them over and examining the bottoms of the mats and the seams". [Id.] "Nurse Violett testified she believed that nurses should inspect each mat, each day, as they make rounds. She

stated that they should lift up the mats to see if there are any tears on the bottom and that nurses should also inspect the seams". [Id.]

The Union contends that it "questions whether or not proper nursing practice requires Unit Managers, such as [Ms. Miller] who are making the rounds to check on their patients when they first come on duty, to lift up mats to see if there are tears on the bottom side of the mats. [Id. at 6].

The Union argues "it would seem there are more important things to observe regarding the condition of the residents rather than inspecting the bottom of floor mats. … There is no evidence, however, that [Ms. Miller] knew the mats were torn in this case. [Id.]

4. Employee Property Incident

While working on a Saturday, the Employer alleges that Ms. Miller acted inappropriately when she failed to call the Director of Nursing at home, to advise her of the fact that a personal photograph of another nurse had been defaced by an unknown third party. The Employer states "on the date that the personal property (an ultrasound print-out) was defaced, Miller was in charge of the shift when the defacing was … discovered. She had also worked on the earlier shift, but was not in charge. According to Interim Director of Nursing Violett's uncontradicted testimony, the defacing should have been immediately reported to Marge Butler, who was training to take over as Director of Nursing at SPCH for follow-up and investigation". [Post-Hearing Brief of Employer at 9].

Ms. Miller testified she herself did not discover that the photograph had been defaced. She testified she was told by another LPN and that later she observed the photograph at the nurses' station. Ms. Miller testified that when she observed the defaced photograph during the second shift, she" wrote a note to the owner of the photograph, advising her that the photograph had been damaged and it had been taken down and that if she had any questions regarding it, she should talk to the Director of Nursing" [Testimony of Nurse Miller at Arbitration Hearing]. Nurse Miller testified that another nurse was the Building Charge Nurse on the second shift and that she believed the Building Charge Nurse was the person who placed the defaced photograph in an envelope and slid it under the Director of Nursing's

door. The Director of Nursing testified that an envelope containing the photograph was on the floor of her office when she came in on Monday but that no one had called her to tell her about the incident over the weekend.

5. Wound Dressing Documentation.

While Nurse Miller was a Unit Manager on the September 13, 2005 shift, an unidentified nurse hired from an agency was assigned by Ms. Miller to take perform specific treatments for a resident in the Unit. One of the treatments was changing the dressing on a wound on the buttocks of the patient. This specific treatment was incorrectly recorded by the agency nurse on the far left-hand column of the treatment record [Employer Exhibit No. 1] as having been done on September 14, 2005. On September 14, 2005, Ms. Miller examined the nurses' notes for the patient [Union Exhibit No. 1] and saw that on September 13, 2005, the agency nurse had written that she had changed dressing on September 13, 2005—not September 14 as the agency nurse had recorded in the treatment record [Employer Exhibit No. 1]. Nurse. Miller made a notation on that treatment record [Employer Exhibit No. 1 that the dressing had been changed on the 13th not the 14th. She did this by putting her initials above that September 13 entry and then also putting her initials on the September 14th date, with her initials on the 14th circled, and with an arrow drawn from the initials drawn on the 14th to the notation on the 13th. Ms. Miller testified that by doing that that she meant to show that the patient's dressing had, in fact, been changed on September 13, 2005, and not September 14. Nurse Miller testified that by circling the initials on the 14th, that meant in nursing code, that the person whose initials are circled, did not perform the function.

Interim Director of Nursing Director Violett wrote:

> On September 15 Kathi Miller told me she wanted to show me on the treatment record for resident, L.M. She referred to the treatment record for September 2005 where it was written "o/a R buttock – solosite & gauze q 3-5 days & PRN. Kathi pointed out that she had signed off for that treatment on 9/13/-5. I asked her if she had done the treatment that day and she said "no, the pool nurse did it." I asked her why she had signed it off in the treatment record. She stated that she wanted people to know that it had been done. I asked her why the pool nurse hadn't signed

> it, since she was the one that did the dressing change. Kathi stated she didn't know why the pool nurse hadn't signed it; she signed to show that it had been done. I asked Kathi if she realized this was false documentation of a legal record. She said, "Well, I just wanted to show that it had been done. Please see the attached document. [Union Exhibit No. 2]

The Employer contends that Ms. Miller "should not have initialed the treatment in any event unless [Nurse] Miller had done the treatment herself. Violett testified that if there was an error in documentation, the correction should have been made on the back of Employer Exhibit No. 1 under generally recognized good nursing practice". [Employer Exhibit No. 1 is the "Treatments/Medications" record for the specific patient].

The Union argues the backside of Employer Exhibit No. 1 is an area marked 'PRN meds and refusal/holds of scheduled meds'. If [Ms. Miller] had done that, it would seem that she would be opening herself up to further criticism for improperly filling out the backside of that documentation because the entry would not deal with medications". [Post-Hearing Brief of Union at 9].

Basically the Employer contends that "all the incidents leading to Miller's termination took place in an approximate one week period". [Post-Hearing Brief of Employer at 11]. The Employer views the incidents as reasons for termination of employment because the issues all deal with the "Employees' honesty and where the comfort and safety of residents is involved". [Id. at 12]. "The termination of Miller is justified upon a finding of the Arbitrator favoring SPCH even on just one of the wheelchair incidents, floor mat incident or the wound care incident. Taking all three together only compounds the wanton disregard for resident care and safety shown by Miller which led to her termination". [Id.]

The Union counters that "the Employer has failed to show 'just cause' for the termination of [Ms. Miller ….] "the Employer failed to prove the wheelchair incident by not calling any witness to rebut the sworn testimony of [Ms. Miller] and [the] nursing assistant …, that the wheelchair was locked when the resident was lifted from and put back on the wheelchair. The Employer failed to establish that as a Unit Manager [Ms. Miller] had an obligation to examine the floor mats daily, by turning them over and looking at the bottom of the mats, when she did have her morning rounds, and even if she should

have done that, her failure to catch the two small tears on the mats in question, does not constitute serious misconduct. With regard to the communication incident, [Ms. Miller] appropriately handled the incident by taking the defaced photograph down, and by writing a note to the owner of the photograph regarding what happened to it. Finally, with regard to the so-called false and dishonest documentation, the evidence reflects that [Ms. Miller] was completely honest with regard to making the correction and she properly corrected the error in the documentation made by the agency nurse". [Post-Hearing Brief of Union at 10].

DECISION AND RATIONALE

The Employer contends that even "just one of the wheelchair incidents" is enough to find just cause for the termination. The Union contends the wheelchair incidents are based solely on hearsay and cannot support just cause for a termination. The Employer submitted the State of Minnesota Inspector's Report. Nurse Miller and the nursing assistant both testified at the Arbitration hearing that they did, in fact, lock the wheels of the wheelchair at each appropriate time. Consequently, the only evidence this Arbitrator has to support the wheelchair incidents is hearsay evidence. *Elkouri and Elkouri, How Arbitration Works*, 6th Edition, Page 348-349 (BNA 2003) states:

> Whether evidence is admissible is a different question from what weight or probative value is to be given to it. For example, where a private investigator's report form the sole basis for the decision, and the report contained unsworn hearsay evidence and lack corroborative testimony, it is admissible, but entitled to little weight.

In *Tamarack, Virginia and Teamsters Local 592*, 95 LA 813 (819), Arbitrator Gallagher in 1990 stated:

> First, the record is lacking a direct first-hand account of the investigatory observations which gave raise to the termination of the grievant. And of equal, if not greater importance, the Union is denied the opportunity to directly challenge the source of the investigatory report through the examination of Mr. Sykes [the private investigator]. Very little, if any weight, can be given to an investigative report which serves as the basis of an Employee's termination when the Union is not afforded the opportunity to cross-examine the author of such a report about the investigatory technique and findings.

The Employer has not sustained its burden of proof with regard to the wheelchair incident.

The next most serious allegation involves the wound care incident. Interim Director of Nursing Violett testified at the Arbitration hearing that the way Ms. Miller corrected the patient's treatment sheet was "false documentation". Nurse Violett testified Ms. Miller should have made the correction on the back side of the sheet rather than correcting it the way she did. Yet the backside of the sheet calls for "PRN meds and refusal/holds of scheduled meds". It does not say anything about "corrections" regarding the front side of the sheet. Nurse Miller testified she herself pointed out the problem to Interim Director of Nursing Violett. Nurse Miller testified she intended to show by her corrections that the Agency Nurse had, in fact, treated the resident's buttocks problems on the "13th" not the "14th". Nurse Miller was trying to correct a mistake made by the Agency Nurse in the resident's documentation. This method of correction, fully transparent, with not intention to mislead does not establish just cause for termination nor, in fact, for any discipline.

The mat incident is problematic. The State Inspectors had cited the St. Paul's Church Home for ripped mats. At a meeting in response to the inspectors report, the need to monitor the mats was discussed with the Nurse Managers, house-keeping workers and Interim Director of Nursing Violett. Nurse Miller testified that after the meeting she had inspected both tops and bottoms of the mats and saw nothing wrong. On the date that Interim Director of Nursing Violett found the rips on the bottoms of the two mats, Nurse Miller said she had inspected the mats at a previous time, but not on that day. Nurse Miller testified that at that early morning hour she was paying attention to the needs of the residents and not inspecting the mats.

Even if it is a requirement of a Nurse Manager to pick up each and every mat every day and examine top and bottom, a violation of such a "requirement" cannot support the termination of a 28-year Employee who has received "above average" to "satisfactory" employee performance appraisals. There was no evidence proffered at the Arbitration hearing to show that a Nurse Manager is required to look

under each floor mat every day as part of "monitoring floor mats in resident's rooms". [Post-Hearing Brief of Employer at 7].

With regard to the defaced photograph, Nurse Miller did what she was reasonably expected to do. She wrote a note to the owner of the photograph and removed the defaced photograph from the nursing station. She was not the Building Charge Nurse on the second shift. She was then working as a Unit Manager on that shift, which was her normal assignment. She had already worked the first shift on that Saturday where she was the Building Charge Nurse. The Building Charge Nurse in charge of the second shift testified that she placed the defaced photograph in the envelope and slid it under the Interim Director of Nursing's door.

Ms. Miller has worked for St. Paul's Church Home her entire adult life. She has been a good Employee for 28 years. Her last evaluation on November 20, 2004 indicates "above average" in all respects except "adherence to policy" for which she received "satisfactory".

Ms. Miller has no prior disciplinary record. The allegations against her do not support just cause for a termination. None of the allegations have been proven by a fair preponderance of the evidence. There is not just cause to support any discipline whatsoever—not termination, not suspension, not a warning. The Grievance is sustained. Ms. Miller is reinstated immediately with full back-pay and benefits less interim earnings. The disciplinary material will be removed from her file.

Dated: January 18, 2006.

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Joseph L. Daly
Arbitrator